

BOARDING HOME RESIDENT RECORD REVIEW

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|--|--------------------------|--------------------------|---|-------------------------------------|----------|--------------|------------|
| BOARDING HOME NAME: | | | | LICENSE NUMBER: | | | |
| INSPECTION DATE: | | | LICENSOR NAME: | | | | |
| Inspection Type: <input type="checkbox"/> Initial <input type="checkbox"/> Full <input type="checkbox"/> Follow up <input type="checkbox"/> Monitoring <input type="checkbox"/> Complaint: #____ | | | | | | | |
| | | | | | | | |
| NAME | | | ID NO. | DATE OF BIRTH | ROOM NO. | MOVE-IN DATE | PAY STATUS |
| FAMILY/MEMBER/RESIDENT'S REPRESENTATIVE/PHONE | | | | PERTINENT MEDICAL HISTORY/DIAGNOSES | | | |
| Yes | No | N/A | Assessment | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pre-admission (For residents admitted in last 3 months). | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Annual to meet resident's needs or semi-annual for EARC – Specialized Dementia Care contract. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Limited for change of condition as needed. | | | | |
| NOTES: | | | | | | | |
| Yes | No | N/A | Monitoring Resident's Well-being | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documented. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Action taken as needed. | | | | |
| NOTES: | | | | | | | |
| Yes | No | N/A | Negotiated Service Agreement (NSA) | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Initial on admission and completed within 30 days (For residents admitted in last 3 months). | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Updated as necessary. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contents meet resident's needs and preferences. <ul style="list-style-type: none"> Defined roles and responsibilities of resident, staff, resident's representative, outside agency if used, and alternate plan when necessary. Times services will be delivered including frequency and approximate time of day. Resident's preferences for activities and how supported. Identifies and incorporates Resident Arranged Services (if applicable). Identifies and incorporates External Health Providers (if applicable) | | | | |
| NOTES: | | | | | | | |
| Yes | No | N/A | Medication Services: <input type="checkbox"/> Independent <input type="checkbox"/> Assistance <input type="checkbox"/> Administration | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Family. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Facility. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appropriate for resident abilities and needs. | | | | |
| | | | Review of medication record. | | | | |
| | | | Documentation of refusal (if applicable) | | | | |
| NOTES: | | | | | | | |
| Yes | No | N/A | Intermittent Nursing Services Provided. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nursing Service System developed. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Services identified and appropriate. | | | | |
| NOTES: | | | | | | | |
| Yes | No | N/A | Modified/Therapeutic Diet. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Receiving Food Services as ordered. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Receiving eating assistance. | | | | |
| NOTES: | | | | | | | |

ATTACHMENT J (Continued)

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|---|----------------|-----------------|
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| Inspection Type: <input type="checkbox"/> Initial <input type="checkbox"/> Full <input type="checkbox"/> Follow up <input type="checkbox"/> Monitoring <input type="checkbox"/> Complaint: #_____ | | |
| ADDITIONAL NOTES: | | |